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NO. 92-16

In The
Supreme Court of the United States
October Term, 1991

MDPHYSICIANS AND ASSOCIATES, INC.,
Petitioner,

V.

STATE BOARD OF INSURANCE, *et al.*,
Respondents.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION

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August 6, 1992

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MDPhysicians and Associates, Inc. Employee Benefit Plan

MDPhysicians, Inc.

Multi-Flex Benefits Systems, Inc.

Paul T. Wrotenbery, former Chairman of Texas State Board of Insurance

Richard F. Reynolds, Member Texas State Board of Insurance

Jo Ann Howard, former Member Texas State Board of Insurance

A.W. Pogue, former Commissioner of Insurance of Texas State Board of Insurance

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BRIEF IN OPPOSITION

Respondent State Board of Insurance[1] respectfully prays that a writ of certiorari be denied in this case because Congress did not intend to shield from State regulation a commercial venture engaged in the business of insurance, but operating under the guise of an ERISA[2] plan.

STATEMENT OF THE CASE

The benefit plan which is the subject of this case was established and maintained by a for profit physicians group

[1]Petitioner lists the State Board of Insurance, Paul T. Wrotenbury, Richard F. Reynolds, Jo Ann Howard, and A.W. Pogue as Parties to the Proceedings. Those parties will be referred to collectively as State Board of Insurance.

[2]Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1001 et seq.

to increase income to that physicians group. The benefit plan's services and functions are indistinguishable from those offered by an insurance company. Moreover, the relationship between the participating employers, their employees, and the benefit plan is identical to the relationship between employers, their employees and an insurance company. However, the benefit plan claims to be an ERISA plan to avoid state examination and solvency requirements.

Petitioner MDPhysicians and Associates, Inc. (MDP) was established by MDPhysicians, Inc., a for profit physicians group. MDPhysicians, Inc. contracts its professional services to exclusive health care providers, such as preferred provider organizations, health maintenance organizations, and insurance carriers. The benefit plan, MDPhysicians and Associates, Inc. Employee Benefit Plan (MDP Plan), was established by MDP and a commercial third party insurance administrator, Multi-Flex Benefit Systems, Inc.[3] The MDP Plan was established to allow MDP to compete more effectively with health maintenance organizations and preferred provider organizations. The MDP Plan enhances MDP's ability to compete by reimbursing 90% of the charges from MDPhysicians, Inc., but only 80% of the charges from other doctors.

MDP not only established the MDP Plan, it also serves as its plan administrator. At the same time, the three officers of MDP serve as trustees for the MDP Plan. Thus, in practice MDP controls the MDP Plan.

One individual serves as executive director for all three entities, the MDP Plan, MDP, and MDPhysicians, Inc.

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[3]The first participating employers in the MDP Plan were employers subscribing to a plan administered by Multi-Flex Benefit Systems, Inc. and rolled over by Multi-Flex into the MDP Plan. However, these employers played no part in establishing and maintaining the MDP Plan.

He is paid $5,000.00 a month, by MDPhysicians, Inc., to administer the MDP Plan.[4]

The participating employers in the MDP Plan have no common relationship other than their membership in the benefit plan. Instead, an employer becomes a participating employer in the MDP Plan by paying the prescribed fees. In exchange for the payment of fees, the MDP Plan promises to pay health benefits to employers of participating employers.[5] The MDP Plan solicits new participating employers through advertising and sales agents. The MDP Plan operates just like commercial insurance companies. The relationship of participants to the MDP Plan is simply that of insured to insurer.

MDP sought a declaratory judgment from the district court that ERISA preempted regulation of the MDP Plan by the State Board of Insurance because the MDP Plan was an employee welfare benefit plan. The Department of Labor (Department) filed an *amicus curiae* brief which concluded that the MDP Plan was not an employee welfare benefit plan under ERISA. Moreover, the Department described the relationship between the participating employers and the MDP Plan as identical to that between the beneficiaries of a group insurance policy and a private insurance company.

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[4]This individual also personally benefits from the MDP Plan by owning 100% of Health Care Delivery Systems, the exclusive provider of pre-certification reviews for the MDP Plan. Each employer pays a $2.00 fee per employee per month for pre-certification reviews.

[5]Notwithstanding MDP's representations to the contrary, Petition at 5-6, the record contains no evidence regarding the "reasonable" cost of the MDP Plan and/or a comparison of those costs and the cost for insurance policies providing the same benefits. Likewise, the record reflects conflicting evidence on the solvency of the MDP Plan. Specifically, the State Board of Insurance found that the MDP Plan's reserves were inadequate and delcared the plan insolvent.

The Department also filed an *amicus curiae* brief at the Fifth Circuit, again concluding that the MDP Plan was not an employee welfare benefit plan because MDP was not an employer within ERISA's definition of that term.

The district court dismissed Petitioner's request for a declaratory judgment for lack of jurisdiction. Petition for Writ of Certiorari (Petition) at 23a. Specifically the district court determined:

> An employee of a subscribing employer has no economic relationship to the physicians who sponsored the MDP Plan. The only relationship between the sponsoring physicians and the employee stems from the benefit plan itself. The relationship between employees and the Plan is like the relationship between a private insurance company and the beneficiaries of a group insurance program.

Id.

Upon appeal, the Fifth Circuit affirmed the district court's dismissal. Specifically, the court concluded: "We hold that MDP did not act as a group or association of employers' in the interest of the Subscribing Employers in relation to the MDP Plan." *Id.* at 16a. Accordingly, the court held that MDP is not an employer within the ERISA definition and the MDP Plan is not an employee welfare benefit plan.

REASONS WHY THE PETITION SHOULD BE DENIED

This Court should deny the petition for writ of certiorari. Petitioner can show no conflict among the circuits in these matters of interpreting the definitions of employer and employee welfare benefit plans. As the Fifth Circuit

noted:

> We suspect the MDP urges [that the definition of employer is clear and unambiguous] . . . because the indications of the Congressional map-makers and the helpful legends supplied by judicial interpreters on journeys similar to ours all counsel against locating the MDP Plan with the borders of ERISA.

Petition at 11a. Additionally, this petition does not present an issue of law which needs to be settled by this Court. Congress, in the very words of ERISA, refused to preempt state regulation of the business of insurance, particularly in the case of a multiple employer welfare arrangement such as the MDP Plan.

I. ERISA's Definition of Employer is Ambiguous and the Lower Courts Properly Interpreted the Term in the Context of the Entire Statute.

The Fifth Circuit clearly and succinctly determined that ERISA's definition of employer is ambiguous. Petition at 8a, 11a. Specifically, the court observed that ERISA does not define the phrase "group or association of employers" which appears in the definition of employer.[6] Accordingly, the court declared that "[t]his void injects ambiguity into the statute." *Id.*

Because of this ambiguity, the Fifth Circuit properly

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[6]ERISA defines employer as follows: "The term employer means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." §3(5), 29 U.S.C.§1002(5).

looked to the context of the entire ERISA statute to determine the meaning of employer. The single definition of employer, any single sentence, does not control the interpretation of a statute. Rather, the court must "look to the provisions of the whole law, and to its object and policy." *Pilot Life Insurance v. Dedeaux*, ___ U.S. ___, ___, 107 S.Ct. 1549, 1555 (1987); *McCarthy v. Bronson*, ___ U.S. ___, ___, 111 S.Ct. 1737, 1740 (1991). ("In ascertaining the plain meaning of [a] statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole.").

ERISA itself describes its purpose and object:

> The Congress finds. . . that the continued well-being and security of millions of *employees* and their dependents are directly affected by these plans, . . . that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans, . . . that owing to the termination of plans before requisite funds have been accumulated, *employees* and their beneficiaries *have been deprived of anticipated benefits*, . . .

29 U.S.C. §1001 (emphasis added).

ERISA's policy and design, thus, is to provide a measure of protection so that benefits promised to employees by their employers are in fact delivered. As part of the bargain, employers benefit from preemption because ERISA employee welfare benefit plans are subject to a uniform set of administrative procedures governed by a single set of regulations. *Fort Halifax Packing Co., Inc. v. Coyne*, ___ U.S. ___, ___, 107 S.Ct. 2211, 2216 (1987). At the

same time, ERISA specifically leaves the regulation of the business of insurance to the individual states. §514(b)(2)(A), 29 U.S.C. §1144; "Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern," 42 VANDERBILT L. REV. 607, 609 (1989).

In interpreting the various provisions of section 514, this Court first recognized that it is "not a model of legislative drafting." *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 722, 739 (1985). Nevertheless, this Court has repeatedly confirmed that ERISA's scheme of preemption is not intended to eradicate the ability of the states to regulate the business of insurance. *FMC Corporation v. Holliday*, ___ U.S. ___, ___, 111 S.Ct. 403, 410 (1990); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 104 (1983).

In this context, then, did the Congress intend a broad, virtually limitless, definition of employer as urged by MDP, thereby allowing purveyors of commercial insurance products to avoid protective state regulation? Petition at 11a-12a. No. Congress did not sanction ERISA preemption from state insurance laws for plans and services undertaken by entrepreneurs and commercial ventures so as to be indistinguishable from insurance companies and insurance policies. *Id.* Indeed, as the Fifth Circuit noted below:

> To allow an entrepreneurial venture to qualify as an "employer" by establishing and maintaining a multiple employer welfare arrangement without input by the employers who subscribe to the plan would twist the language of the statute and defeat the purposes of Congress.

Id. at 14a.

In reaching this conclusion, the Fifth Circuit joined three other circuits in determining that ERISA does not preempt state insurance regulation of entrepreneurial ventures. *Wayne Chemical, Inc. v. Columbus Agency Service Corporation*, 567 F.2d 692, 699 (7th Cir. 1977) (Congress would have had no reason to exempt from state regulation insurance programs that are established and maintained by entrepreneurs for their own profit); *Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982); *Wisconsin Association Insurance Trust v. Iowa State Board of Public Instruction*, 804 F.2d 1059, 1964 (8th Cir. 1986)(an overly broad definition of employee welfare benefit plans ignores congressional intent to limit such plans to situations where the nexus between the plan's sponsor and all its beneficiaries excludes it from the state-regulated entrepreneurial arena in which private insurance companies operate). *See also Credit Managers Association v. Kennesaw Life and Accident Insurance Company*, 809 F.2d 617, 625 (9th Cir. 1987) (heterogenous, unrelated employers do not constitute group or association of employers).

Nevertheless, MDP asserts that ERISA's definition of employer must be given its broadest interpretation because multiple employer welfare arrangements (MEWAs) "create a vehicle for providing quality health coverage at an economical cost to small and medium size employers who could not afford such coverage in the traditional insurance marketplace." Petition at 11. Moreover, MDP insists that any requirement that employers participate in the management of MEWA would be a disincentive to subscribe. *Id.* at 10. MDP has completely missed the point. ERISA preempts the application of state laws to employee welfare benefit plans because Congress has concluded that the employees will receive the promised benefits if a relationship, separate from the benefit plan, exists between the employees and their employer or employee organization.

Wisconsin Association Insurance Trust v. Iowa Board of Public Instruction, 804 F.2d at 1064. In the absence of that relationship or nexus, there can be no employee welfare benefit plan and state regulation of MEWAs is not preempted.

The 1983 amendments to ERISA confirmed that state insurance regulation of MEWAs, such as the MDP, is not preempted. In describing the MEWA amendment, Congressman Erlenborn stated:

> The provisions of the amendment are consistent with the original intent of Congress in excluding the multiple employer welfare arrangements which do not meet the "employee welfare benefit plan" definition from the scope of coverage and preemption provisions of ERISA.

See Appendix A at 5a, Remarks of Congressman Erlenborn. Additionally, Congressman Erlenborn adopted the Activity Report of the Pension Task Force, Committee on Education and Labor (94th Cong., 2d. sess. 1977) which concluded that for profit commercial ventures were not, and are not, employee benefit plans under ERISA. *Id.* Therefore, by its own terms, ERISA provides that a non-fully insured MEWA, which is not an employee welfare benefit plan, such as MDP, is to be fully regulated by state insurance authorities. §514(6)(A), 29 U.S.C. §1144.

In sum, ERISA's definition of employer is ambiguous. However, the context and purpose of ERISA confirm an interpretation of that definition that is far less encompassing than Petitioner's suggested expansive reading.

II. Assuming that the MDP Plan is an Employee Welfare Benefit Plan, Requiring MDP to Obtain a Certificate of Insurance is not Inconsistent with ERISA.

As just discussed, ERISA does not preempt state regulation of MEWAs which are *not* employee welfare benefit plans. §514(b)(6)(A), 29 U.S.C. §1144. Therefore, if the Court concurs with the holdings of the district court and the Fifth Circuit, the Court does not need to reach Petitioner's question 2.[7]

However, assuming that MDP is an employee welfare benefit plan, the requirement that the MDP Plan obtain a certificate of insurance is not inconsistent with the provisions of ERISA. ERISA provides no minimum standards or requirements for employee welfare benefit plans. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. at 732. There are, then, no requirements or regulations concerning solvency of or potential reserves for an employee welfare benefit plan.

In contrast, the extensive state regulation of insurance companies can be divided into three categories: first, laws directly regulating the insurer by inquiring into solvency of the company and qualifications of the company's management; second, laws regulating aspects of the business of insurance such as claims practices and rates; and third, laws regulating the content of policies. *Id.* at 728. The requirement that the MDP Plan obtain a certificate of authority is the means by which the State of Texas enforces its authority to inquire into solvency and management.

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[7]The Fifth Circuit read the district court's discussion of the certificate of authority requirements as *dicta*. Petition at 3a. At best, the district court's discussion of the certificate of authority requirement is a holding in the alterative. Petition at 23a.

Article 1.14 of the Texas Insurance Code provides that an insurance carrier which has complied with all aspects of state laws shall be issued a certificate of authority. *See* Appendix B at 10a. In determining whether to issue a certificate of authority, the State Board of Insurance may inquire into the "competence, fitness and reputation of the officers and directors," §3, art. 1.14, Tex. Ins. Code. *See also* art. 1.14A, TEX. INS. CODE (a certificate of authority may not be issued to an insurance carrier if a corporate officer or member of the board of directors has been convicted of a felony involving breach of a fiduciary duty), Appendix B at 11a. Additionally, the insurance carrier must submit to an examination to determine the sufficiency of the company's capital. art. 3.06, TEX. INS. CODE, Appendix B at 12a-13a. Thus, receiving a certificate of authority reflects that the State Board of Insurance has reviewed the management and assets of the insurance company. This process is neither duplicative nor in conflict with the reporting and fiduciary requirements of ERISA.

Petitioner concedes that state "statutes requiring funding levels, reserves, and annual audits" are not inconsistent with ERISA. Petition at 18. However, Petitioner never explains how obtaining a certificate of authority is more onerous than complying with funding level and reserve requirements, two integral components of the process of obtaining a certificate of authority. Petitioner's only argument that a state statute requiring a certificate of authority is inconsistent with ERISA is that Congress could not have intended to sanction the transformation of a self-funded MEWA into an insurance company. Petition at 16. Once again, Petitioner has read ERISA far too broadly. As has been discussed above, ERISA sanctions very limited preemption of state insurance laws in the case of MEWAs. §514(b)(6)(A), 29 U.S.C. §1144; Appendix A at 6a; *MEWAs, Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to*

Federal and State Regulation, U. S. Department of Labor, Pension and Welfare Benefits Administration, Division of Public Affairs, 1991, at 37, 41.

CONCLUSION

Petitioner has failed to show any special and important reasons for granting the petition for writ of certiorari. To the contrary, the Fifth Circuit's decision is squarely in line with other circuits in interpreting the provisions of ERISA at issue. Additionally, the words of ERISA themselves reflect the clear Congressional intent to limit preemption of state insurance regulation of MEWAs. Accordingly, Respondent respectfully requests that the petition for writ of certiorari be denied.

Respectfully submitted,

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APPENDIX A

CONGRESSIONAL RECORD-HOUSE December 13, 1982
Pages 30356-3038

Mr. Erlenborn. Mr. Speaker, the amendments being offered to the legislation we are now considering (H.R. 5470) are severalfold. The provisions relating to the Internal Revenue Code have been considered by the committee having jurisdiction over those matters, the Committee on Ways and Means. The provisions relating to the amendment to ERISA, the Employee Retirement Income Security Act of 1974 (Public Law 93-406) which was added in the other body are solely within the jurisdiction of the Committee on Education and Labor and have been the subject of hearings held this year by the Subcommittee on Labor-Management Relations.

The agreed amendments to ERISA are corrective in nature. These amendments to ERISA section 514 serve to reaffirm the board Federal preemption of State laws as they relate to employee benefit plans as was the original intent of ERISA.

The first amendment which adds a new paragraph (5) to ERISA section 514(b) will enable the Hawaii Prepaid Health Care Act (Haw. Civ. Stat. 393-1 through 51) to be administered in a limited fashion after the date of enactment of H.R. 5470. Last year the Supreme Court let stand the decision of the Ninth Circuit Court of Appeals in Standard Oil Company of California against Agsalud that the board preemptive framework relating to both pension and welfare (for example, health) plans agreed to by the ERISA conferees does in fact supersede the Hawaii statute. The agreement to amend ERISA to permit the future application of the Hawaii law was reached solely on the basis and with the understanding that the Hawaii law is an unusual special case, inasmuch as the law was enacted just prior to the signing of ERISA on September 2, 1974, and that the law will be permitted to operate only as a narrow exception which is not expected to do violence to the strong Federal preemption scheme. In agreeing to the Hawaii exception this body will

be reaffirming the broad scope of ERISA preemption and the validity of the interpretation of the Federal courts in connection with the Hawaii statute. To help allay the fears of those who might otherwise view this action as the beginning of a weakening of Federal Preemption under ERISA, the amendment contains an explicit statement that this limited exception shall not be considered a precedent with respect to extending similar treatment to any other State law.

It should be noted that the provision of the Hawaii law which triggered the Standard Oil challenge remains preempted under the new exception. In fact any amendment to the Hawaii Prepaid Health Care Act enacted after September 2, 1974, is preempted except to the extent such amendment provides only for the effective administration of the law effective as of such date.

STOP METS ABUSE

The other issue addressed by the ERISA amendments are also the subject of H.R. 6462, a bill which the chairman of the Subcommittee on Labor-Management Relations, Phillip Burton, and I introduced on May 21 to put a stop to what the attorney general in my state, Illinois, has characterized as an increasing problem having the potential to become the "most sophisticated and profitable white-collar crime in America." In a growing number of States across the Nation, operators of bogus insurance trusts are bleeding the trusts of funds and claiming bankruptcy, thus leaving thousands of people holding the bag for millions of dollars in unpaid hospital and medical bills. The ensuing tragedies of the victims, personal bankruptcies, and damages personal credit ratings, serve notice to this Congress of the urgent need to enact the proposed legislation this year.

On March 5, the subcommittee held hearings in Chicago, Ill., to investigate the problems caused by these so-

called multiple employer health trust--or MET's. Our proposed legislative solution is an outgrowth of the consensus which emerged at the hearing among the interested parties--State and Federal regulators, the insurance industry, the actuarial profession, and legitimate health plan sponsors. The language in the amendment is a modification of that found in H.R. 6462 and reflects suggestions made by the Department of Labor.

Generally, the abuses connected with MET's can be and, in some cases, have been dealt with under appropriate State laws. Unfortunately, the MET operators have been successful in thwarting timely investigations and other enforcement activities of State agencies by asserting that such entities are ERISA plans for which all State regulation is preempted pursuant to section 514 of the Employee Retirement Income Security Act of 1974 (ERISA). In all too many cases, the result has been that State remedial actions have come too late to head off insolvency and benefit losses stemming from the mismanagement and misdeeds of the MET operators. This has proved to be the general rule in spite of the steps taken by the Department of Labor to clarify the jurisdictional role of the States in regulating MET's. In fact the ERISA Administrator in the Department of Labor has testified that in virtually all of the cases in which the Department has issued an opinion as to the coverage of a MET entity under ERISA, the entity in question has been found not to qualify as an employee welfare benefit plan with respect to which the ERISA preemption provision applies. The proposed legislation closes off all avenues of opportunity that might currently exist for MET operators to avoid such regulation at the Federal and State level, as may be applicable in each particular circumstance.

EXPLANATION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENT PROVISIONS

OVERVIEW

The amendment defines the term "multiple employer welfare arrangement" to include all forms of what have come to be known in the insurance trade as multiple employer trusts or MET's. These arrangement may provide benefits--typically hospital and medical benefits--on a fully insured basis or on a basis that does not involve the full guarantee of benefit payments by a licensed insurance company. Some of the arrangements may meet the definition of "employee welfare benefit plan" under ERISA, and, thus, are currently regulated at the Federal level as ERISA plans; others do not meet the ERISA plan definition, and thus, are subject to whatever existing regulation may apply to such entities at the State level. Under the proposed amendment to ERISA's preemption provisions, the scope of State regulation is clarified with respect to all such arrangements whether or not they are fully insured or meet ERISA definition of "plan."

The amendment reaffirms the original intent of Congress in enacting the Employee Retirement Income Security Act of 1974 (ERISA) that if a multiple employer welfare arrangement does not meet the definition of an employee welfare benefit plan under the act, then such an entity is not exempted--under the preemption provisions set forth in section 514 of ERISA--from the application of State insurance and other laws regulating such entities. With respect to arrangements which meet the definition of ERISA plans, the amendment specifically permits State regulation in varying degrees depending on the type of arrangement and whether or not the arrangements is determined by the Department of Labor to be an ERISA covered welfare benefit plan. Thus, the amendment removes any potential obstacle that might exist under current law which could hinder the ability of the States to regulate multiple employer welfare arrangements to assure the financial soundness and timely

payment of benefits under such arrangements.

DEFINITION

A new paragraph (40) is added to section 3 of ERISA which defines the term "multiple employer welfare arrangement." This term includes employee welfare benefit plans now covered under ERISA as well as other arrangements (so-called MET's) which are not covered under ERISA as plan entities. Any such arrangement which is established or maintained under or pursuant to one or more collective bargaining agreements is excluded from the scope of the term. Also excluded are plans or other arrangements maintained by a single employer. "Single employer" is defined to include two or more trades or businesses within the same control group.

The provisions of the amendment are consistent with the original intent of Congress in excluding those multiple employer welfare arrangements which do not meet the "employee welfare benefit plan" definition from the scope of the coverage and preemption provisions of ERISA. In this regard, the position of the Committee on Education and Labor was clearly stated in the Activity Report of the Pension Task Force (94th Cong., 2d sess., 1977):

It has come to our attention, through the good offices of the National Association of State Insurance Commissioners, that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in the profiting from the provisions of administrative services are establishing insurance companies and related enterprises. The entrepreneur will then argue that his enterprise is an ERISA benefit plan which is protected under ERISA's preemption provision from state regulation.

We are concerned with this type of development, but

on the basis of the facts provided us, we are of the opinion that these programs are not "employee benefit plans" as defined in Section 3(3). As described to us, these plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction, nor is the purpose for their establishment or maintenance appropriate to meet the jurisdictional prerequisites of the Act. They are no more ERISA plan than is any other insurance policy sold to an employee benefit plan.

LIMITATION OF PREEMPTION OF STATE LAW

Section 514 of ERISA is amended to make clear the extent to which State law is preempted with respect to employee welfare benefit plans which also meet the new multiple employer welfare arrangement definition.

Multiple employer welfare arrangements that do not meet the ERISA welfare plan definition are unconditionally subject to the State law. Such arrangement (i.e. MET's) are not regulated as plan entities under ERISA. This policy was reinforced in Wayne Chemical Inc. against Columbus Agency Service Corp., in which the Court of Appeals for the Seventh Circuit stated: Congress would have had no reason to exempt from state regulation insurance programs that are established and maintained by entrepreneurs for their own profits.

With respect to multiple employer welfare arrangements which do meet the definition of welfare plan, the amendment amends the ERISA preemption provision to permit limited State regulation of such plans while retaining the full scope of the Federal regulation which is presently applicable. The amendment to the preemption provision is necessary since State regulation is fully preempted under present law.

The amendment identifies two different categories of plan arrangements which may be subject to State regulation. In the first category are welfare plans which first are either fully insured but have obtained an exemption from the Department of Labor that they meet the ERISA "employee welfare benefit plan" definition. States may regulate such plans under their insurance laws, but such regulation is restricted to standards requiring the maintenance of contribution and reserve levels considered necessary for such plans to pay promised benefits in full when due.

In the second category are all other welfare plans which first, meet the definition of multiple employer welfare arrangement, second, are not fully insured, and third, have not obtained the above mentioned exemption from the Department of Labor. These plans are subject to ERISA and whatever State law may apply to them (except to the extent that the State law may be inconsistent with the Federal law under title I of ERISA).

Another provision (new ERISA section 514(b)(6)(C)) clarifies present law and deals with a question which has arisen as to whether ERISA applies to any aspect of a multiple employer welfare arrangement which dies not meet the ERISA welfare plan definition (hereinafter referred to as a MET).

Since employers frequently subscribe to these MET arrangements to provide employees with welfare benefits, there is a strong presumption that ERISA applies. The Department of Labor, which has taken the position that the MET itself does not constitute a single umbrella-like employee benefit plan, has consistently maintained that each employer or union which subscribes to the MET has established its own employee benefit plan. Under this analysis, the MET is not a single large plan, but rather a funding vehicle for a number of small individual employee benefit plans.

This analysis does not jeopardize the application of State law to the MET because it is clear even under present

law that State law may apply to funding vehicles for plans; for example, State insurance laws obviously apply to licensed insurance companies which underwrite benefits in a number of individual employer or union established employee benefit plans. It also fills a gap in State law by subjecting the operators of the MET to the reporting, disclosure, and fiduciary standards of ERISA to the extent they are administrators and fiduciaries to these subscribing welfare plans.

The Department of Labor's analysis is entirely consistent with the congressional intent under ERISA. Nevertheless, the Court of Appeals for the Fifth Circuit, in *Taggart Corp. v. Life & Health Benefits Administration*, 617 F.2d 1208 (5th Cir. 1980), has held that ERISA does not apply to the plans which subscribe to the MET. Even more disturbing is the reasoning of this decision which holds that employers which purchase insurance to underwrite benefits and/or which hire third parties to administer the plans do not establish welfare plans covered by ERISA. This reasoning is wholly inconsistent with the language of ERISA, its legislative history, the case law and the shared understanding of the employee benefit plan community. It is also a critical issue because it affects the jurisdictional scope of ERISA.

While there is every reason to believe that the courts will readily see the error of the *Taggart* decision (e.g., the Court of Appeals for the 11th Circuit has in an en banc hearing ruled that ERISA applies to the "plans" that subscribe to a MET) to reconsider the *Taggart* decision, section 514(b)(6)(C) makes it clear that welfare plans which subscribe to or use MET's as a funding vehicle are subject (as ERISA plans) to the applicable provisions of title I, including the preemption provisions (which preempt State law in connection with such plans).

EXEMPTION FOR CERTAIN PLANS

A new section 514 (b)(6)(B) is added to ERISA which allows multiple employer welfare arrangements which are not fully insured to apply to the Secretary of Labor for an exemption from section 514(b)(6)(A)(ii) if they meet the requirements under sections 3(1) and 4 necessary to be considered employee welfare benefit plans to which title I applies.

Legitimate ERISA plans which obtain such an exemption will, as a result, be subject only to those standards of State law specified in section 514(b)(6)(A)(i). The Secretary of Labor would not have to consider any application for an exemption unless the Secretary determines that an exemption process pursuant to regulations is necessary.

In summary, the amendment would allow added protection of State law to apply to multiple employer welfare arrangements by: First, clarifying that non-ERISA plan MET's are fully subject to State law; second, allowing State insurance law which does not conflict with ERISA to apply to nonfully insured, noncertified ERISA plan arrangements; and third, allowing State financial solvency requirements to apply to fully insured, and certified ERISA plan arrangements. It is not intended that fully insured ERISA plans will be subject to increased regulation at the State level. In fact, the National Association of Insurance Commissioners has provided written assurance that it is not the intent of any State insurance commissioner to regulate these fully insured plans or the underlying insured in a manner different from that which occurs at present. It is expected that the Department of Labor will provide applicable State insurance commissioners with immediate notice of any application for exemption under section 514(b)(6)(B).

APPENDIX B
TEXAS INSURANCE CODE

Art. 1.14. Shall Issue Certificate of Authority

Section 1. No individual, group of individuals, association or corporation, unless now or hereafter otherwise permitted by statute, shall be permitted to engage in the business of insuring others against those losses which may be insured against under the laws of this state. Should the State Board of Insurance be satisfied that any insurance carrier applying for a certificate of authority has in all respects fully complied with the law, it shall be its duty to issue to such carrier a certificate of authority, under its seal, authorizing such carrier to transact insurance business, naming therein the particular kinds of insurance business. Each such certificate of authority heretofore or hereafter issued shall be in full force and effect until it is revoked, canceled or suspended according to law; provided,however, that failure to file any annual statement required by law will subject the certificate of authority to being revoked, canceled or suspended.

* * *

Section 3. The Board may inquire into the competence, fitness and reputation of the officers and directors of each carrier and of any person having control of such carrier. As used in this section, "control" and "person" have the meanings assigned by Section 2, Article 21.49-1 of this code. If, after inquiry, and based on substantial evidence, it shall appear to the Board that such officers, directors and any person having control of such carrier, or any of them, are not worthy of the public confidence, it shall give such carrier notice in writing of its intention to refuse the application for Certificate of Authority, or to revoke the

certificate once granted, stating specifically why the Board intends such action, and the place and time for hearing by the Board, not sooner than ten (10) days nor later than twenty (20) days thereafter.

After notice and hearing, the Board shall forthwith record in its official minutes its findings and order, which shall be subject to full review as provided by Article 1.04(f) of this code. Provided, however, that fraternal benefit societies that sell insurance policies only as an incidental benefit to their members and which are now so organized and licensed by the Board of Insurance Commissioners of Texas or which are now exempt under the provisions of Article 10.12 or Article 10.38 of the Insurance Code are hereby exempted from the provisions of this Act.

Art. 1.14A. Ineligibility for Certificate of Authority Based on Felony Conviction

(a) Except as provided by Subsection (c) of this section, the department may not issue a certificate of authority to an insurance company if a corporate officer or a member of a board of directors of the company has been convicted of a felony involving moral turpitude or breach of a fiduciary duty.

* * *

Art. 3.06. Original Examination and Certificate

When the application for charter, articles of incorporation, affidavit, and charter fee are filed with the State Board of Insurance and before the hearing required by Article 3.04 of this Code, the Board shall make, or cause to be made, at the expense of the company, a full and thorough examination thereof. After the hearing under Article 3.04 of this Code, if the Board finds that all of the capital of the company, as required by law, has been fully paid up and that

the capital and surplus is in the custody of the officers, in cash or securities of the class authorized by Article 3.02 of this Code as amended, and if the Board makes the other findings required by Section 3 of Article 3.04 of this Code favorably to the applicant, Article 3.04 of this Code, the Board shall issue to such company a certificate of authority on compliance with the other requirements of this article and to transact such kind or kinds of insurance business within this State as such officer may apply for and as may be authorized by its charter. Before such certificate is issued, not less than two (2) officers of such company shall execute and file with the State Board of Insurance a sworn schedule of all the assets of the company exhibited to the Board upon such examination showing the value thereof, together with a sworn statement that the same are bona fide, the unconditional and unencumbered property of the company, and are worth the amount stated in such schedule.